Department of Health
*Office of Emergency Medical & Trauma Prevention*

# AIR AMBULANCE SERVICE / VEHICLE LICENSURE / TRAUMA VERIFICATION APPLICATION

Service Name: _____ / _____
*(Legal Name)* *(Also Known As)*

Address: _____ EMS Agency/License #: _____
*(If known)*

_____

City: _____ State: _____ Zip: _____

Owner/Operator: _____ Phone: _____

Physician Director: _____ Phone: _____

EMS Training Officer: _____ Phone: _____

E-Mail Address: _____ FAX: _____

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**NOTE:** If your agency operates as an Air Ambulance AND Ground Ambulance, a separate application is required for each part of the operation.

**TRAUMA VERIFICATION REQUESTED?** Yes ☐ No ☐

**DOES YOUR SERVICE UTILIZE EMS PERSONNEL?** Yes ☐ No ☐

**IF UTILIZING EMS PERSONNEL, PLEASE CHECK THE LEVEL OF CARE PROVIDED ON A 24-HOUR BASIS:** BLS ☐ ILS ☐ ALS ☐

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**ORGANIZATION TYPE:** (check the one that ***best*** applies to your organization)

Private For Profit ☐ Private Non-Profit ☐ Private Volunteer Association ☐
Hospital District ☐ EMS District ☐ Other (specify below) ☐

_____

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**VEHICLES:** Please provide the **number** of each type vehicle you are licensing (see page 2):

Air Ambulance (Fixed Wing) ☐ Air Ambulance (Rotary Wing) ☐

**RESPONSE INFO:** Please provide the **number** for each EMS activity listed below, for your last full calendar year (*if applicable, i.e. when changing the existing type of service. First time applicants need not provide this information*)**:**

Primary Responses ☐ Transports Primary/Secondary ☐
Secondary Responses ☐ Interfacility Transports *Only* ☐

**PERSONNEL STATUS:** Are your EMS personnel primarily: (check one) Paid ☐ Volunteer ☐

**DO NOT DUPLICATE**

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# EMERGENCY MEDICAL *VEHICLES*

Please provide the following information for all air ambulance vehicles to be licensed. Vehicle location is the address in which the vehicle is **physically located.** Check the ***type*** of vehicle(s), fixed or rotary wing. Check to see that each licensed vehicle has a license sticker appropriately displayed. If there is no sticker, request one below.

**YOUR SERVICE NAME:** _____

| | YEAR | MAKE AND MODEL | LICENSE PLATE OR FAA NUMBER | ACTUAL ADDRESS OF VEHICLE *(If Different From Page 1)* | AIR AMB FIXED | AIR AMB ROTARY | STICKER NEEDED (Yes or No) |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |
| 6 | | | | | | | |
| 7 | | | | | | | |
| 8 | | | | | | | |
| 9 | | | | | | | |
| 10 | | | | | | | |
| 11 | | | | | | | |
| 12 | | | | | | | |

**Attach extra sheets as necessary, including all the required information.**

**NOTE:** When *adding, removing*, or *changing* the location of licensed vehicles, contact the appropriate licensing office, at the address or telephone number on Page 4.

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# EMERGENCY MEDICAL *PERSONNEL*

List all medical personnel in your organization who are providing emergency care, aid or transportation, and check the appropriate column(s). Include personnel who are full or part-time, paid or unpaid.

**PLEASE KEEP A COPY OF THIS LIST ON FILE FOR INSPECTION BY THE DEPARTMENT OF HEALTH.**

**SERVICE NAME:** _____

| | NAME (LAST, FIRST, M.I.) | EMT | IV TECH | AW TECH | IV/AW TECH | ILS TECH | LS/AW TECH | PM | OTHER (Specify) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| 6 | | | | | | | | | |
| 7 | | | | | | | | | |
| 8 | | | | | | | | | |
| 9 | | | | | | | | | |
| 10 | | | | | | | | | |
| 11 | | | | | | | | | |
| 12 | | | | | | | | | |
| 13 | | | | | | | | | |
| 14 | | | | | | | | | |
| 15 | | | | | | | | | |
| 16 | | | | | | | | | |
| 17 | | | | | | | | | |
| 18 | | | | | | | | | |
| 19 | | | | | | | | | |
| 20 | | | | | | | | | |
| | **PLEASE TOTAL EACH COLUMN:** | | | | | | | | |

**Attach additional sheets as necessary, including all the required information.**

**Legend:**
**EMT** = Emergency Medical Technician
**IV TECH** = Intravenous Therapy
**AW TECH** = Airway Technician
**IV/AW TECH** = IV and Airway
**ILS TECH** = Intermediate Life Support
**ILS/AW TECH** = ILS & Airway
**PM** = Paramedic
**OTHER** = RN, MD, PA, Flight Nurse

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# GENERAL OPERATION

Please describe the **general operation** of your service; including how it will operate in a manner consistent with WAC 246-976, the State EMS & Trauma Plan. *(Please find this information on our website at **www.doh.wa.gov/hsqa/emtp** **click on "Licensure Processes."** If you require hard copies of this information, please contact the appropriate Licensing and Certification office, shown at the bottom of this application).* Provide an explanation of your:

1. **Dispatch plan**

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2. **Response plan**

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3. **Response area**

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4. **Type of transport (emergency and/or interfacility), if any**

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5. **Tiered response and rendezvous, if any**

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6. **Back-up plan to respond**

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**NOTE:** Other services involved in your response plan must be informed by you that they are participants and must agree to that participation. Attach extra sheets as necessary.

***"I/We hereby affirm and declare that the information provided is true and correct and that:***

1. *Our service operates in a manner, which is consistent with the State EMS & Trauma Plan;*
2. *Our service, and all vehicles submitted for licensure on Page 2, meet minimum requirements provided in WAC 246-976 (Air Ambulance Services);*
3. *Our service meets all FAA regulations;*
4. *A copy of our current FAA certificate and operational specifications is attached to this application;*
5. *Our Physician Director is a Washington-State licensed physician;*
6. *We maintain current liability insurance coverage (copy attached)."*

**Person Completing Application** (Print or Type) **Date**

**Owner/Operator** (Signature & Title) **Date**

## DO NOT DUPLICATE